

9-1-1997

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Recommended Citation

Bharati Sadasivam, *The Rights Framework in Reproductive Health Advocacy -- A Reappraisal*, 8 Hastings Women's L.J. 313 (1997).
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The Rights Framework In Reproductive Health Advocacy -- A Reappraisal

by *Bharati Sadasivam**

INTRODUCTION

The reproductive rights and reproductive health movement is more pre-eminent now than at any other time. At its heart is the conviction that the right to reproductive choice and freedom is intrinsic to the control of one's life and to human dignity. The movement has gained momentum and legitimacy through the United Nations Decade for Women and the historic United Nations (UN) world conferences of the '90s, notably the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing. These conferences have explicitly recognized that the human rights of women include their right to control and decide matters relating to sexual and reproductive health.

Today there is wide acceptance by governments and other national and international actors of the principle of reproductive rights as a basic human right. This right encompasses two key categories: the right to reproductive choice and the right to quality reproductive health care. Reproductive choice involves the right to reproductive decision-making, i.e., to control one's body and make decisions about child-bearing, sexuality, and well-being. It was expressed as a basic human right in the 1968 Teheran International Conference on Human Rights.¹ The right to reproductive health care entails a right of access to health services, including family planning and quality of care, which can be exercised on the basis of informed consent, free of discrimination, coercion, and violence.² These enunciations of reproductive rights have led to a conceptualization of reproductive health as a positive state of personal well-being, and not merely the absence of

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1. FINAL ACT OF THE INTERNATIONAL CONFERENCE ON HUMAN RIGHTS at 14-15, U.N. Doc. A/CONF.32/41, U.N. Sales No. E.68.XIV.2 (1968) [hereinafter TEHERAN DECLARATION]. See also *infra* note 12.

2. UNITED NATIONS, REPORT OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT at 43-44, U.N. Doc. A/CONF.171/13 (1994) [hereinafter CAIRO PROGRAMME OF ACTION].

disease or infirmity.³

The formal articulations of reproductive rights and the clear textual support for them are, however, in stark contrast to the realities of women's lives in most parts of the world. The gap between principle and practice underscores the many factors that make reproductive health advocacy a complex and difficult task. Foremost among them is the fact that women's exercise of their reproductive rights depends on the enforcement of their general human rights. Women's health, their reproductive health in particular, is not just a biological process for which they must bear personal responsibility. Rather, the general and reproductive health of women is contingent upon several enabling conditions, which can be social, economic, or political. Health advocates and human rights scholars have argued that health is a socially produced good that needs a combination of civil and political rights (the right to decide the number and spacing of children) and economic and social rights (the availability of contraceptives and safe and affordable health services) to attain the highest standard of sexual and reproductive health.⁴ Such a conceptualization not only puts the spotlight on government action and inaction in the realization of women's reproductive rights, but also calls attention to the many deep-rooted forms of discrimination and gender bias in the home, community and workplace that impede women's right to reproductive health.

The discrimination women face in the health arena is widely documented. More than half a million women, most of them in developing countries, die each year during childbirth and from pregnancy-related causes.⁵ Women also suffer from a higher proportion of reproductive health-related diseases.⁶ Moreover, in large parts of Asia and Africa, serious gender-based disparities in food and health care within the family have led to the phenomenon of "missing women."⁷

3. *Id.* at 43. See *infra* note 27 and accompanying text.

4. See, e.g., Lynn P. Freedman, *Reflections on Emerging Frameworks of Health and Human Rights*, 1 HEALTH AND HUM. RTS. 314 (1995).

5. UNITED NATIONS, THE WORLD'S WOMEN, 1995: TRENDS AND STATISTICS at 75, U.N. Doc. ST/ESA/STAT/SER.K/12, Sales No. E.95.XVII.2 (1995).

6. The World Health Organization and the World Bank have made quantitative assessments of the global burden of different diseases, and expressed the results in terms of disability-adjusted life years (DALYs). Thirty million DALYs lost were attributed to maternal causes. The global burden of sexually transmitted diseases is estimated to be 17.2 million DALYs for women, as compared to 3.8 million DALYs for men. Mahmoud F. Fathalla, *From Family Planning to Reproductive Health*, in BEYOND THE NUMBERS: A READER ON POPULATION, CONSUMPTION AND THE ENVIRONMENT 143, 146-47 (Laurie A. Mazur ed., 1994).

7. The female-male ratio (FMR) in South Asia, China, West Asia and North Africa averages 0.93 or 0.94 to 1, in contrast to 1.05 observed in developed countries. The higher

A second challenge to reproductive health advocacy hinges on the issue of control. A woman's ability to control what happens to her body and to make decisions about her reproduction and sexuality are central to reproductive rights. Providing women with reproductive autonomy is a prospect that evokes unease and outright opposition from families, political and religious powers, and from nations. Women's bodies have become contested terrain among these entities. State-run family planning programs in many countries, especially China, India, and Indonesia, manipulate women's reproductive capacities to achieve societal demographic goals. Similarly, the religious right and pro-life movements in the United States vehemently oppose abortion as a means of reproductive control. As manifested by women's experiences in numerous conflicts in all parts of the world, such as the former Yugoslavia, Haiti, Rwanda, and Somalia, women's reproduction is a tool for political projects such as eugenics, 'ethnic cleansing,' or rape as an instrument of war.⁸

Finally, reproductive health advocacy can find itself stymied by an over-reliance on the rights framework to advance its goals. As the reservations⁹ by various governments to international human rights instruments and recent UN conference documents have shown, the rights language can further politicize deeply sensitive issues of reproduction and sexuality, hardening conservative positions and frightening away potential allies. Just as a globalized concern over rapid population growth does not provide useful guidance for action by na-

mortality of women, despite the female biological advantage at birth, is due in large part to serious anti-female bias in the provision of food and health care. Higher female mortality cannot be attributed to poverty: Sub-Saharan Africa's FMR is 1.02. If the FMR in other parts of the developing world were the same as in Sub-Saharan Africa, the proportion of missing women would be 44 million in China and over 35 million in India. See, e.g., Jean Drèze & Amartya Sen, HUNGER AND PUBLIC ACTION 51-53 (1989); Ansley J. Coale, *Excess Female Mortality and the Balance of the Sexes in the Population: An Estimate of the Number of "Missing Females,"* POPULATION AND DEV. REV., Sept. 1991, at 517; THE WORLD BANK, IMPROVING WOMEN'S HEALTH IN INDIA 15-18 (1996).

8. See, e.g., HUMAN RIGHTS WATCH, THE HUMAN RIGHTS WATCH GLOBAL REPORT ON WOMEN'S HUMAN RIGHTS (1995), for a detailed documentation of sexual violence, rape and other forms of gender-based torture inflicted upon women in countries worldwide by militant groups, military agents, and state officials during wars and refugee movements and in state custody. In a January 1996 report, the United Nations Special Rapporteur on Rwanda found that "rape was the rule and its absence the exception." The Rapporteur noted the difficulties in documenting the actual occurrence of sexual violence during the Rwandan genocide, partly because of women's fear in reporting it and the failure of investigators to document gender-based crimes in war. See HUMAN RIGHTS WATCH, SHATTERED LIVES: SEXUAL VIOLENCE DURING THE RWANDAN GENOCIDE AND ITS AFTERMATH 24 (1996).

9. Article 2(d) of the Vienna Convention defines a reservation as "any unilateral statement, however phrased or named, made by a State, when signing, ratifying, accepting, approving or acceding to a treaty, whereby it purports to exclude or to modify the legal effect of certain provisions of the treaty in their application to that State." Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S. 331.

tional governments, the assertion of principles of universality in the international context cannot guarantee the protection of women's health and rights in individual countries and communities.

Ultimately, the rights discourse in reproductive health advocacy has emphasized the sheer complexity of the intersection between the health and human rights fields, even as it has been undeniably successful in developing a movement and expanding the context for women's health. Theoretically, advocates, activists, and non-governmental organizations (NGOs) are empowered now as never before by the stated global consensus on reproductive rights. In practice, however, they are challenged by a host of economic, political and socio-cultural forces against which the reproductive rights movement is increasingly having to define itself.

This article begins by tracing the evolution of reproductive rights in the international legal system and by examining the scope of the legal framework used to advance reproductive health goals. It goes on to discuss the interface between treaty law and soft law with government practice and to show how purely rights-based advocacy strategies can be counterproductive to women's interests in certain contexts. Instead, a health services approach would allow NGOs to gear their advocacy strategies toward practical and definable service outcomes, while adhering to the philosophical underpinnings of human rights. Such an approach, not inconsistent with a rights approach, would not only focus on how health systems can be made more efficient and responsive to women's needs but also enable cash-poor governments to make incremental efforts and encourage cooperative interaction between activists and policymakers. Finally, the article outlines possible rights-oriented practical strategies to achieve reproductive health goals, concluding that such results-oriented strategies can better serve women's health interests than conventional human rights advocacy and the adversarial stances it often necessitates.

I. THE INTERNATIONAL LEGAL FRAMEWORK

A. Reproductive Rights in 'Soft Law':¹⁰ From Teheran to Beijing

Reproductive rights are the legal expressions of the principle that women, as well as men, are entitled to control their reproductive lives. Today, the principle of reproductive rights has come to mean the right to bodily control and integrity and to make decisions con-

10. UN General Assembly resolutions and platforms of action from UN conferences constitute non-traditional forms of law-making, or "soft law." See, e.g. Christine Chinkin, *The Challenge of Soft Law: Development and Change in International Law*, 38 INT'L & COMP. L.Q. 850 (1989).

cerning reproduction free of coercion, discrimination, and violence.¹¹ This conceptualization of reproductive rights has taken several decades to evolve, emerging first out of the international population movement, and then becoming redefined and elaborated by the women's health and human rights movements. The trajectory is worth reviewing to understand the contrary pulls and pressures that continue to plague the reproductive rights movement today and hamper the translation of rights principles into practice.

Health was first articulated as a human right in the Universal Declaration of Human Rights in 1948.¹² However, neither the Declaration nor the two principal International Covenants on civil and political rights and economic, social, and cultural rights of 1966 enunciated reproductive rights as human rights.¹³ The international community recognized for the first time at the 1968 International Conference on Human Rights in Teheran that parents had the "basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect."¹⁴

However, the underlying principle of this "basic human right" at Teheran was not women's reproductive freedom but population control. Meeting against the backdrop of cataclysmic projections of unchecked population growth made by Paul Ehrlich¹⁵ and others who

11. UNITED NATIONS, REPORT OF THE FOURTH WORLD CONFERENCE ON WOMEN at 5, U.N. Doc. A/CONF.177/20 (1969) [hereinafter BEIJING PLATFORM FOR ACTION].

12. Article 16(1) of the Universal Declaration of Human Rights (UDHR) states: Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. G.A. Res. 217A (III), U.N. Doc. A/810 at Art. 16(1) (1948) [hereinafter UDHR]. Article 25(1) of the UDHR states:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Id. at Art. 25(1).

13. International Covenant on Civil and Political Rights, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171, S. TREATY DOC. No. 95-2 [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 6, 1966, 933 U.N.T.S. 3 [hereinafter ICESCR]. Article 23.2 of the ICCPR recognizes "[t]he right of men and women of marriageable age to marry and to found a family . . ."

14. TEHRAN DECLARATION, *supra* note 1. Since then, the right to determine the number and spacing of children has been amplified and reaffirmed by numerous international documents and instruments, including the World Population Plan of Action of 1974, the Mexico International Conference on Population in 1984, and the Amsterdam Declaration of 1989. See, e.g., KATARINA TOMAŠEVSKI, WOMEN AND HUMAN RIGHTS 17-23 (1993), for a discussion of the evolution of reproductive rights from protection of motherhood to equal rights for women.

15. PAUL EHRLICH, THE POPULATION BOMB (2d ed. 1971).

echoed Malthusian fears of over-population,¹⁶ the delegates at Teheran proclaimed a right to reproductive autonomy as a means to limit rapid world population growth.¹⁷

The early articulations of a reproductive right thus emanated from the population control movement and quickly became entrapped within a North-South framework.¹⁸ After a tense tug-of-war between the doomsday prophets of the North and the "development first" proponents of the South, the World Population Plan of Action adopted in Bucharest in 1974 redefined the right to reproductive decision-making, stating:

All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community¹⁹

The Bucharest resolution significantly expanded the concept of reproductive rights to cover all couples and individuals, recognizing that they had to have not only information and education but the means to control their reproduction. Reproductive rights now in-

16. The Malthusian thesis is that unchecked population growth will outrun the earth's capacity to sustain human beings. In 1798, when there were fewer than one billion people on earth, Malthus wrote that "the period when the number of men surpass their means of subsistence has long since arrived." THOMAS R. MALTHUS, *ESSAY ON THE PRINCIPLE OF POPULATION AS IT AFFECTS THE FUTURE IMPROVEMENT OF SOCIETY WITH REMARKS ON THE SPECULATION OF MR. GODWIN, M. CONDORCET AND OTHER WRITERS* (1798). However, global rates of food production have kept ahead of population growth. See Sen, *infra* note 18.

17. See, for example, Paragraph 7 of the World Population Plan of Action, which states: Individual reproductive behavior and the needs and aspirations of society should be reconciled. In many developing countries, . . . the desire of couples to achieve large families is believed to result in excessive national population growth rates and Governments are explicitly attempting to reduce those rates by implementing specific policy measures.

UNITED NATIONS, INTERNATIONAL CONFERENCE ON POPULATION, WORLD POPULATION PLAN OF ACTION, at 5, ¶ 7, U.N. Doc. E/CONF.76/BP/1 (1984) [hereinafter WPPA].

18. The "world population problem," according to industrialized countries of the North (and some Third World elites), is a consequence of rapid population growth among the poor which they contend is a primary cause for degradation of the environment. The nations of the South argue that it is the consumption and lifestyle patterns of the North rather than population growth that takes a toll on the environment, and that birth rates among the poor cannot be expected to decline in the absence of development that leads to overall improvement in health and economic conditions. See, e.g., Amartya Sen, *Population: Delusion and Reality*, NEW YORK REVIEW OF BOOKS (Sept. 22, 1994) for a discussion of the population and development debate.

19. WPPA, *supra* note 17, at 7, ¶ 14(f).

cluded two components: the freedom to decide how many children to have and when to have them, and the entitlement to family planning services.²⁰ In 1973, the United Nations declared that "the ability to regulate the timing and number of births is one central means of freeing women to exercise the full range of reproductive rights to which they are entitled."²¹

Beginning with the launch of the United Nations Decade for Women in 1975, the international women's rights movement had to reclaim reproductive rights from population controllers and a new force, the "right-to-life" movement, that was starting to make its presence felt in the international arena, propelled largely by anti-choice groups in the United States.²² By the end of the 1970s, an increasing number of women's health and human rights coalitions, particularly in the developing world, had begun to feel the need to clarify the right to reproductive choice in opposition to the population control movement, the anti-choice movement, and other forces that had made women's bodies "a pawn in the struggles among states, religions, male heads of households, and private corporations."²³

The Declaration of the first International Women's Conference in Mexico City in 1975 firmly grounded its assertion of the right to reproductive choice in the principle of bodily integrity and control. It

20. WPPA, *supra* note 17, at 11, ¶ 29(b), (c), (e) & (g).

21. Rebecca J. Cook, *International Protection of Women's Reproductive Rights*, N.Y.U.J. INT'L L. & POL. 645, 683-84 (1992) (quoting UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON THE STATUS OF WOMEN, REPORT OF THE SPECIAL RAPPORTEUR: STUDY ON THE INTERRELATIONSHIP OF THE STATUS OF WOMEN AND FAMILY PLANNING, U.N. Doc. E/CN.6/575/Rev.1 (1973)).

22. This powerful lobby succeeded in persuading the Reagan administration to prohibit the Agency for International Development and NGOs from using U.S. foreign aid for abortion as a means of family planning. The Helms Amendment to the U.S. Foreign Assistance Act of 1973 on this subject is still in force. The Clinton Administration's support for U.S. international population assistance has been opposed by conservatives in the Congress and anti-abortion forces who contend that they are actually conduits for President Clinton's worldwide "abortion crusade." In February 1997, Republican Congressman Christopher Smith, responding to U.S. Secretary of State Madeleine Albright's appeal to Congress to release \$215 million for family planning programs overseas, stated, "I believe the real consensus is with providing family planning funds but not, however unwittingly, empowering the pro-abortion movement overseas to bring down the right-to-life laws as they exist in approximately 100 countries of the world." Katherine Q. Seelye, *Family Planning and Foreign Policy are Linked, Albright Tells House Panel*, N.Y. TIMES, Feb. 12, 1997, at A20. Republican Senator Tim Hutchinson said it was "wrong to ask pro-life American taxpayers to foot the bill for that which they find morally offensive and morally wrong." Katherine Q. Seelye, *Senate Backs Family Planning Aid Overseas*, N.Y. TIMES, Feb. 26, 1997, at A12.

23. Lynn P. Freedman & Stephen L. Isaacs, *Human Rights and Reproductive Choice*, 24 STUD. IN FAM. PLAN. 18, 23 (Jan./Feb. 1993) (quoting GITA SEN & CAREN GROWN, DEVELOPMENT, CRISIS, AND ALTERNATIVE VISIONS: THIRD WORLD WOMEN'S PERSPECTIVES 49 (1987)).

also began to outline reproductive health principles in reproductive rights:

It should be one of the principal aims of social education to teach respect for physical integrity and its rightful place in human life. The human body, whether that of woman or man, is inviolable and respect for it is a fundamental element of human dignity and freedom.

Every couple and every individual has the right to decide freely and responsibly whether or not to have children as well as to determine their number and spacing, and to have the information, education and means to do so.²⁴

The significant success of the international women's movement, both at Mexico City in 1975 and in Nairobi in 1985, was a result of shifting the perspective from reproductive rights to women's autonomy from the societal need for fertility decline.²⁵ However, the inherent tension between the population control and the women's rights movement on the question of reproductive behavior is reflected in the right to "decide freely and responsibly" the number and spacing of children, which has formed the basis of every articulation of reproductive rights since Teheran. The "freedom" of the individual to decide is always to be limited by the "responsibility" to make the decision within the framework of population policies imposed for the societal good.²⁶

Faced with this problematic contradiction, women's health advocates have had to redefine reproductive rights from a woman's perspective. A vast body of feminist scholarship has contributed greatly to the still-evolving understanding of women's right to reproductive rights and reproductive health. In essence, advocates and feminist scholars have de-linked reproductive rights from population control to promote the perspective that women have an unencumbered right to reproductive health and choice. They emphasize that this right should be protected from manipulation by individuals, states, or collectives. Women's rights advocates have also called for the recognition of women's right to health, including reproductive health, because it is socially and politically dependent upon the environments women inhabit.

24. REPORT OF THE WORLD CONFERENCE OF THE INTERNATIONAL WOMEN'S YEAR at 5, U.N. Doc. E/CONF.66/34, U.N. Sales No. E.76.IV.1 (1976).

25. REPORT OF THE WORLD CONFERENCE TO REVIEW AND APPRAISE THE ACHIEVEMENTS OF THE UNITED NATIONS DECADE FOR WOMEN: EQUALITY, DEVELOPMENT AND PEACE at 39, U.N. Doc. A/CONF.116/28/Rev.1, U.N. Sales No. E.85.IV.10 (1985).

26. Freedman, *supra* note 4, at 336.

This holistic approach to reproductive rights is reflected at the 1994 Cairo conference on population and development, where a Programme of Action encompassing a broad spectrum of reproductive and sexual health needs was developed.²⁷ The Cairo Programme of Action is noteworthy not only for making reproductive health the centerpiece of family planning programs and policies, but also for its articulation of a comprehensive concept of reproductive health.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,²⁸ in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexu-

27. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 44-45.

Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in Paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood

Id.

28. This is also the definition of health in the World Health Organization, suggesting broader social rather than purely medical parameters for health. CONSTITUTION OF THE WORLD HEALTH ORGANIZATION (1946), *reprinted in* WORLD HEALTH ORGANIZATION, BASIC DOCUMENTS 1 (40th ed. 1994).

ally transmitted diseases.²⁹

This articulation challenges traditional demographically-driven family planning approaches that focus on averting births and popularizing contraception rather than on human well-being. The Cairo Programme of Action's concept of reproductive health makes people the subjects rather than the objects of family planning, providing an ethical justification for redesigning programs and policies to reflect personal and social concerns.³⁰

Three essential principles of reproductive rights can be distilled from the Cairo Programme of Action: (1) the right to freely decide the number and spacing of children, and the right to have the information and means to do so; (2) the rights to attain the highest standard of sexual and reproductive health; and (3) the right to make decisions concerning reproduction free of coercion, discrimination, or violence.³¹

Gender equity and gender equality were addressed in the preamble and the principles that provide the framework for the entire document, and an entire chapter of the Programme of Action was de-

29. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 43.

30. ROUNDTABLE ON ETHICS, POPULATION AND REPRODUCTIVE HEALTH, DEVELOPMENT LAW AND POLICY PROGRAM, DECLARATION OF ETHICAL PRINCIPLES 2 (Columbia University). In fact, the Cairo Programme of Action rejects the standard Malthusian terminology used by the population establishment in favor of the language of reproductive and sexual health and reproductive rights. The sub-section on family planning in Chapter VII of the document specifically criticizes the target orientation that has strongly characterized family planning programs in the South countries, stating that:

Over the past century, many Governments have experimented with . . . specific incentives and disincentives, in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients.

CAIRO PROGRAMME OF ACTION, *supra* note 2, at 46.

31. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 15. Although the Cairo conference represented a big step forward from the population control to the reproductive health approach, it did not fully succeed in resolving the contentious issues of abortion, sexual orientation, and sexual rights in favor of women. Conservative forces such as the Vatican and some Islamic nations formed unlikely coalitions across religious and political lines to block inclusion of these issues in the final document. It is important to note, however, that the number of countries entering reservations on reproductive health-related questions has declined in successive UN conferences. Some 45 countries entered reservations in Cairo, 32 at the Beijing conference, and 12 at the 1996 UN Conference on Human Settlements (Habitat II) in Istanbul. "The small number of anticipated reservations reflects growing inter-governmental and international support for the Cairo and Beijing agendas." Susan Davis & Anita Nayar, *An Analysis of the U.N. Conference on Human Settlements Istanbul Declaration and Habitat Agenda 2* (June 14, 1996)(WOMEN'S ENV'T & DEV. ORG., NEW YORK, N.Y.).

voted to these issues.³² The reproductive health goals formatted in Cairo were reaffirmed at the 1995 Beijing Women's Conference, which placed reproductive rights squarely within "human rights already recognized in national laws, international human rights documents and other consensus documents."³³ The Beijing Platform for Action was also the first non-treaty document to recognize gender bias and inequality and gender stereotypes as significant barriers to the attainment of women's health.³⁴

The declarations and statements from these conferences have established the human right of couples and individuals to reproductive choice and freedom. Taken together, they constitute a vast body of "soft law" which, although lacking the binding nature of treaty law, has undeniable value in advancing reproductive health goals. First, these declarations and statements add to the practice of customary law. Although UN conference documents are not legally binding, they are politically enforceable since they represent a consensus among all member nations. Second, they shape domestic law by giving advocates the language to make legal demands, foster a rights debate and ensure informal obligations on the part of state and non-state actors. The impact of conference statements and declarations on customary and domestic law is critical given the scant international and domestic jurisprudence on women's health and the absence of case law. The scope and vision of the Cairo and Beijing documents, in particular, with the public commitments made by signatory governments, make them potentially effective bargaining tools in the

32. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 15. Chapter IV, *Gender Equality, Equity and Empowerment of Women*, begins with the statement that:

The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of sustainable development. The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household.

CAIRO PROGRAMME OF ACTION, *supra* note 2, at 35.

33. BEIJING PLATFORM FOR ACTION, *supra* note 11, at 39. Paragraph 96 goes further than the Cairo Programme of Action in its recognition that "[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." *Id.*

34. Paragraph 89 of the Beijing Platform for Action states: "A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups." *Id.* at 37. Paragraph 90 states: "Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women." *Id.* at 37.

hands of women's health and human rights advocates.

B. Reproductive Rights in Treaty Law

The Convention on the Elimination of All Forms of Discrimination Against Women, also known as the Women's Convention, is the only international normative instrument to explicitly codify the right to reproductive choice, drawing upon earlier formulations.³⁵ Several articles of the Women's Convention provide a clear legal basis for the obligation of States Parties³⁶ to address issues related to women's reproductive health.³⁷ The Women's Convention is also the first international legally binding treaty in which States Parties assume the duty to eliminate discrimination against women in all civil, political, economic, social, and cultural areas, including health care and family planning.³⁸ By ratifying the Women's Convention, countries undertake a positive legal duty to "pursue, by all appropriate means and without delay, a policy of elimination of discrimination against women."³⁹ Through invoking the prohibition of all forms of discrimination against women, the Convention endows women with the right to control their fertility, a fundamental key that opens the door to women's enjoyment of other human rights.⁴⁰

Moving beyond the Women's Convention, advocates have taken another step toward identifying a normative basis for reproductive and sexual rights, the general right to health in international law. The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes "the right of everyone to the enjoyment of the

35. "States Parties shall take all appropriate measures to . . . ensure on a basis of equality of men and women the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, 1249 U.N.T.S. 13, at Art. 16(1)(c) [hereinafter Women's Convention].

36. Nations that ratify or accede to a treaty are known as States Parties.

37. Article 11(1)(f) of the Convention commits States Parties to ensure "the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction." Women's Convention, *supra* note 35. Article 11 (2) (a) and (b) call for the prevention of discrimination on grounds of marital status, pregnancy or maternity and protection of employment, seniority and social allowances on these counts. *Id.* Article 11(2)(d) calls for the provision of "special protection to women during pregnancy in types of work proved to be harmful to them." *Id.*

38. Rebecca J. Cook & Jeanne M. Haws, *The United Nations Convention on the Rights of Women: Opportunities for Family Planning Providers*, 12 INT'L FAM. PLAN. PERSP. 49, 49 (1986).

39. Women's Convention, *supra* note 35, at Art. 2.

40. Tomaševski notes that although the texts of the Political and Economic Covenants, adopted in 1966, stress the principle of non-discrimination, they do not specifically include gender discrimination, instead addressing women only as mothers. TOMAŠEVSKI, *supra* note 14, at 100. It was only with the adoption of the Women's Convention in 1979 that women's human rights received international legal regulation. *Id.*

highest standard of physical and mental health.”⁴¹ If understood in the broad framework of health as defined in the World Health Organization (WHO) Constitution, the realization of reproductive rights implicates a range of civil, political, economic, social, and cultural rights beyond those concerned only with health care. For example, because gender discrimination prevents equal access to health care, women’s right to health specifically implicates several provisions of the Women’s Convention.⁴² The aggregate of rights comprising women’s right to health is thus found in a range of human rights instruments including the Conventions against racial discrimination and those on the rights of the child.⁴³

Clearly, the important interconnections between reproductive rights and human rights must underpin reproductive rights campaigns. A woman’s right to decide the number and spacing of her children depends upon her status, her ability to safeguard her own health and that of her family, and her right to act as an independent adult. It also depends on her ability to participate as a citizen in her community, to earn a living, to own and control property and to be free from discrimination on the basis of gender, race, class, and religion. Ultimately, reproductive choice is meaningful only when it is part of this full constellation of rights.

C. Feminist Critiques

Feminist concerns over the pursuit of rights-based approaches in reproductive health advocacy focus on three areas. The first is the gender-blind nature of international law. The development of feminist jurisprudence in recent years has produced insightful commentary on gender bias inherent in purportedly gender-neutral treaties and conventions in international law. Feminist scholars have called attention to the ways in which the public/private distinction in normative

41. ICESCR, *supra* note 13, at Art. 12(1). Article 12(1)(a) of the ICESCR calls for steps to prevent stillbirths and infant mortality but not, however, maternal mortality.

42. Article 12(1) of the Women’s Convention requires States Parties “to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.” Women’s Convention, *supra* note 35, at Art. 12(1).

43. For example, the International Convention on the Elimination of All Forms of Racial Discrimination *opened for signature* Mar. 7, 1996, 660 U.N.T.S. 195, S. TREATY DOC. NO. 95-2, at Art. 5(e)(iv) [hereinafter CERD], guarantees the “right to public health, medical care, social security and social services.” Under the Convention on the Rights of the Child, “States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her access to such health care services.” Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A.Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, 169, U.N. Doc. A/44/49 (1990).

structures of international law serves to further the dominance of male interests and perpetuate the subordination of female concerns.

The public/private distinction, which is central to western liberal theory, is an ideological construct based on deeply held beliefs about gender. The public sphere of power and authority is the world of the workplace, law, economics, and politics and is regarded as the natural realm of men. The private sphere of the home, hearth, and family is seen as the natural domain of women. At the level of the nation-state, the distinction implies that the private sphere is beyond the reach of the state's legal powers. In fact, the state exercises its power in the private sphere in several ways through the regulation of taxes, education, health, and welfare measures. In the international legal order, the distinction suggests that public international law can concern itself only with the relations between nation-states. In contrast, feminist scholars argue that the public/private distinction in certain principles of international law has served to privilege male perspectives and further male dominance in the international legal order.⁴⁴

Without interference from human rights guarantees operating in the public sphere, the public/private distinction legitimizes repression or neglect outside the public domain. In the context of reproductive health, the absence of human rights guarantees in the private sphere has permitted the violation of the most obvious human right, the right to life, to go unrecognized.⁴⁵ The right to life has usually been interpreted in the context of the public domain where the understanding of this right has been mainly in terms of the obligation of nations to ensure that courts observe due process of law before capital punishment is imposed.⁴⁶ This interpretation has tended to obscure the reality that the right to life is violated daily by death in pregnancy and childbirth, which could have been avoided if women enjoyed better health and better access to reproductive health services. More than half a

44. Hilary Charlesworth, et al., *Feminist Approaches to International Law*, 85 AM. J. INT'L L. 613 (1991). The authors point out that the right to freedom from torture and other cruel, inhuman and degrading treatment, which is a key civil and political right in all major instruments of international law, covers pain or suffering inflicted by a "public official." Such a definition relies on the public/private distinction and obscures the kinds of pain and injuries typically suffered by women. *Id.* at 628.

45. ICCPR, *supra* note 13, at Art. 6.1

46. The Human Rights Committee has noted that "the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot be properly understood in a restrictive manner, and the protection of this right requires that States adopt positive measures." The Committee suggested that States Parties to the Political Covenant take all possible measures to reduce infant mortality and increase life expectancy. UNITED NATIONS, HUMAN RIGHTS COMMITTEE, GENERAL COMMENTS, ADOPTED BY THE HUMAN RIGHTS COMMITTEE UNDER ARTICLE 40, PARAGRAPH 4 OF THE INTERNATIONAL CONVENTION ON CIVIL AND POLITICAL RIGHTS, at 5, U.N. Doc. CCPR/C/21/Rev.1 (1989). For a more extensive discussion of this issue, see Charlesworth et al., *supra* note 44; Cook, *supra* note 21.

million women die each year during childbirth or from pregnancy-related causes, an overwhelming majority of them in developing countries. This is a tragedy that demands the attention of the entire international community as both a health and a human rights issue for which governments should be held accountable. As a result, feminist legal scholars have argued that the right to life in international law must be interpreted in a broader context that includes the private sphere.

Apart from illustrating how the public/private distinction in international law works to exclude the experiences of women, the neglected tragedy of maternal mortality also highlights the fact that traditional canons of human rights law offer little redress in cases of a pervasive, structural denial of rights.⁴⁷ The failure of states to provide services aimed at reducing maternal risk in childbirth is arguably a case of such structural denial, as are state-run population programs which practice coercive population control techniques that suppress the right to reproductive choice and freedom.

In addition to the gender-blind nature of international law, another feminist concern relates to the implementation of the Women's Convention. As illustrated by the patterns of reservation to this treaty, patriarchal norms and practices that subordinate women continue to go unchallenged in nations throughout the world. By making numerous reservations to this treaty, ratifying states have clearly expressed their intentions to implement its provisions only if they are not in conflict with existing religious or customary laws in their countries pertaining to women's rights in marriage, inheritance, property, economic opportunities, and freedom of movement.⁴⁸ The Women's Convention lacks mechanisms both to question the substantive basis of the reservations and to restrict their number, thereby ceding ground to national governments and enabling them to address women's inequality on their own inequitable terms.⁴⁹ The weakness of implementation procedures among human rights treaty bodies,

47. Charlesworth et al., *supra* note 44, at 625-34.

48. The caveat contained in Article 28(2), that reservations should be compatible with the object and purpose of the treaty, provides no criteria to determine incompatibility. Women's Convention, *supra* note 35.

49. Although reservations are not intended to allow governments to contradict themselves, it is an unfortunate feature of the Women's Convention that it is one of the most reserved conventions in the world. Moreover, the reservations entered by states have in many cases gone against the very principle of non-discrimination. This shows governments' resistance and apathy to protection of women's rights and also illustrates the difficulties inherent in making governments respond to women's human rights even when international and national pressures combine forces. See, e.g., Rebecca J. Cook, *Reservations to the Convention on the Elimination of All Forms of Discrimination Against Women*, 30 VA. J. INT'L L. 643 (1990).

particularly in the committee to monitor the implementation of the Women's Convention, is a significant obstacle to the attainment of women's human rights.⁵⁰ Finally, while the attention accorded to women's special concerns in the Convention is an important advancement, this has also had the paradoxical effects of marginalizing women's perspectives within the UN system by relegating them to one convention, rather than being made part of mainstream human rights bodies and movements.

The third and fundamental feminist critique of rights-based approaches revolves around the very location of reproductive rights. Although both couples and individuals are entitled to reproductive rights in all current international instruments, these rights remain essentially within the family and conjugal union, which is for all intents and purposes a heterosexual partnership constituted along traditional patriarchal lines.⁵¹ The Beijing Platform did not openly challenge the conventional definition of 'family.' It only made a guarded statement that the family exists in various forms.⁵² This potential expansion of

50. In the absence of an Optional Protocol which would allow individual women to bring complaints before it, the committee monitors progress on the implementation of the Convention through government reports, which are to be submitted every four years. Many government reports are late in coming and/or of poor quality. CEDAW members discuss the reports at public sessions in the presence of the country representative, but do not declare when a nation's law, policy or practice breaches the Convention. As a result, CEDAW has never formally pronounced a State Party a violator of the Convention, even when its record is seen to warrant it. TOMAŠEVSKI, *supra* note 14, at 123. For a more extensive discussion of the weakness of CEDAW as a monitoring body, see Karen Engle, *International Human Rights and Feminism: When Discourses Meet*, 13 MICH. J. INT'L L. 570-75 (1992).

51. Article 16(3) of the Universal Declaration of Human Rights states, "[t]he family is the natural and fundamental group unit of society and is entitled to protection by the society and the state." UDHR, *supra* note 12, at Art. 16(3). Note that the Cairo Programme of Action's reference to "various forms of the family" is followed by the sentence: "Marriage must be entered into with the free consent of the intending spouses, and husband and wife should be equal partners." CAIRO PROGRAMME OF ACTION, *supra* note 2, at 16.

52. "Women play a critical role in the family. The family is the basic unit of society and as such should be strengthened. It is entitled to receive comprehensive protection and support. In different cultural, political and social systems, various forms of the family exist." BEIJING PLATFORM FOR ACTION, *supra* note 11, at 15 (emphasis added). The Beijing Platform for Action comes the closest to acknowledging the plurality of family forms, despite the exclusion of the words 'lesbian' and 'sexual orientation' from the final conference document. Some gay and lesbian rights activists see this as a step forward, and not a failure. The conference marked the first time in history that all the world's governments held a prolonged and extensive debate on sexual orientation. After the debate, nearly 30 governments went on record with explicit 'interpretive' statements to say that they considered the Platform language, even without specific reference to sexual orientation, sufficiently inclusive to bar all forms of discrimination, including on the basis of sexual orientation. Susan Davis, *What's the Verdict? What Was Won by Lesbians at the U.N.'s Fourth World Conference on Women?* (1995) (on file with the Women's Env't and Dev. Org., New York, N.Y.).

the definition of 'family' suggested a recognition of the possibility that there may be room within this articulation for 'alternative families' formed by gays and lesbians. Inevitably, it prompted a host of clarifying statements and reservations from several states. For example, the Holy See stressed that "the family is the basic unit of society and is based on marriage as an equal partnership between husband and wife, to which the transmission of life is entrusted." It said that it can "only interpret such terms as 'women's right to control their sexuality,' 'women's right to control ... their fertility' or 'couples and individuals' as referring to the responsible use of sexuality within marriage." Expressing its reservation to "women's right to control their sexuality," the Holy See said "this ambiguous term could be understood as endorsing sexual relationships outside heterosexual marriage."⁵³ Several states, including the Holy See, Guatemala, Argentina, the Islamic Republic of Iran, Libya and Malaysia, echoed this traditional interpretation of the family and marriage.⁵⁴

This patriarchal definition of family and marriage ignores the intrinsic inequities within the family structure. The stereotypical gender roles and unequal power relations between the sexes within the family perpetuate violence, coercion and domination, all of which curtail women's right to attain the "highest standard of sexual and reproductive health."⁵⁵ A growing body of work by feminist economists and sociologists has shown that the family is not necessarily a homogeneous and harmonious entity that respects and fosters the rights and capabilities of each of its members.⁵⁶ Ultimately, the expansion of

53. BEIJING PLATFORM FOR ACTION, *supra* note 11, at 161.

54. For example, the Islamic Republic of Iran stated that it "upholds the principle that safe and responsible sexual relationships between men and women can only be legitimized within the framework of marriage. Moreover, the phrase, 'couples and individuals,' should also be interpreted in that context." BEIJING PLATFORM FOR ACTION, *supra* note 11, at 163. At Cairo, Honduras stated that "the terms 'family composition and structure,' 'types of families,' 'different types of families,' 'other unions' and similar terms can only be accepted on the understanding that in Honduras these terms will never be able to mean unions of persons of the same sex." CAIRO PROGRAMME OF ACTION, *supra* note 2, at 138. Paraguay submitted that its national constitution "considers that the family is the basic unit of society and is based on the union of a couple – man and woman – recognizing as well single-parent families." *Id.* at 140.

55. CAIRO PROGRAMME OF ACTION, *supra* note 2, at ¶7.3.

56. There is a growing literature on feminist critiques of the neoclassical view of the household. See, e.g., NAILA KABEER, REVERSED REALITIES: GENDER HIERARCHIES IN DEVELOPMENT THOUGHT 95-135 (1994), for a discussion of different views of the household as an altruistic entity and as a site of bargaining and conflict and their implications for household welfare. See also Nancy Folbre, *Hearts and Spades: Paradigms of Household Economics*, 14 WORLD DEV. 245; Amartya Sen, *Gender and Cooperative Conflicts*, in PERSISTENT INEQUALITIES 123 (Irene Tinker ed., 1990). Feminists view the family not as a nuclear unit but as a heterogeneous social phenomenon undergoing fundamental changes. The proliferation of female-headed households throughout the North and South is a clear

individual rights and economic opportunities challenges traditional notions of family relationships, creating demands for the recognition of new formulations of rights of which the international legal community is only beginning to become aware.⁵⁷

II. LAW AND ADVOCACY

While laws ensuring reproductive choice and freedom are necessary, one cannot legislate reproductive health since its attainment is contingent upon several enabling conditions, which are also politically determined. The interdependence between the law and the political and social environments challenges the philosophical basis for a reproductive right, with critical implications for advocacy. There is real ground for disagreement between those who view reproductive rights as "natural rights," an inalienable part of each individual's essential humanity, and those who see these rights as socially determined needs derived from the unequal gender relations that prevail in most societies.⁵⁸ Regardless of the viewpoint, the legal framework for reproductive health is essential for conceptualizing the ways in which law interfaces with policy and actual government practice. From the standpoint of advocacy, this interface is one of the most problematic aspects of employing legal norms to advance women's health goals.

A. Institutional Barriers

1. Government-Sponsored Family Planning Programs

NGOs and health advocates seeking to utilize the instruments of law should recognize that while the individual's right to reproductive choice and freedom and dignity of person were being conceptualized at the international level, government-sponsored family planning programs in several developing countries, aimed solely at reducing fertility, severely curtailed these rights.⁵⁹ Concern in industrialized coun-

example. See SONIA CORRÊA & REBECCA REICHMANN, *POPULATION AND REPRODUCTIVE RIGHTS: FEMINIST PERSPECTIVES FROM THE SOUTH* 2-3 (1994) (published in association with Development Alternatives with Women for a New Era).

57. For example, a 1996 UN document notes that "[r]ather than relying on the institutional definitions of family imputed by the State, notions of the family should be reconceptualized around expressions of ideals of nurturance and care. There is a need to make room for 'difference and plurality' within our understanding of what constitutes family." UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON HUMAN RIGHTS, REPORT OF THE U.N. SPECIAL RAPPORTEUR ON VIOLENCE AGAINST WOMEN, ITS CAUSES AND CONSEQUENCES, MS. RADHIKA COOMARASWAMY, SUBMITTED IN ACCORDANCE WITH COMMISSION ON HUMAN RIGHTS RESOLUTION 1995/85, at ¶ 25, U.N. Doc. E/CN.4/1996/53 (1996) [hereinafter *SPECIAL RAPPORTEUR REPORT*].

58. ROSALIND P. PETCHESKY, *ABORTION AND WOMEN'S CHOICE: THE STATE, SEXUALITY AND REPRODUCTIVE FREEDOM* 2 (1990).

59. Nearly 130 governments currently subsidize family planning services in their countries. In 1990, low- and middle-income countries spent more than \$4 billion on family

tries and donor nations about the global "population problem" has led to unqualified support for family planning programs even at times of overall cutbacks in development aid.⁶⁰ Donor assistance is contingent on the success of the programs in bringing down the birth rate. Only secondary consideration is given to the provision of reproductive health care, or the multitude of women's health needs.

For example, in three of the world's most populous countries, China, India, and Indonesia, the official family planning programs have explicit goals of population control and long-standing records of neglect of women's health needs and coercion.⁶¹ The anti-natalist programs in these nations provide glaring examples of the troubling contradiction created by the universal right of individuals to "decide freely and responsibly" the number, spacing and timing of their children. In countries such as Singapore and Malaysia, the right to freedom in reproductive decision-making is greatly undermined by pro-natalist government policies aimed at selected income and ethnic groups.⁶² In other nations, the state is directly responsible for reproductive rights abuses through eugenic actions aimed at reducing what

planning each year. Worldwide, over eighty per cent of all contraceptive users receive their supplies and services from public sector programs. Anika Rahman & Rachael Pine, *An International Human Right to Reproductive Health Care: Toward Definition and Accountability*, 1 HEALTH AND HUM. RTS. 400, 403 (1995).

60. In 1995, the United States, a major donor to international population programs, allotted eight per cent of its total official development assistance (ODA) to population programs—a combination of declining total ODA and increasing support for population and reproductive health. UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON POPULATION AND DEVELOPMENT, FOLLOW-UP ACTIONS TO THE RECOMMENDATIONS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT: INTERNATIONAL MIGRATION, U.N. Doc. E/CN.9/1997/6 (1997) [hereinafter FOLLOW-UP ACTIONS].

61. Since its inception in 1952, the Indian family planning program has focused on reducing fertility rates. The Indian government's Eighth Five-Year Plan (1992-97) continues to focus on containing population growth "through active people's cooperation and an effective scheme of incentives and disincentives." GOVERNMENT OF INDIA, EIGHTH FIVE-YEAR PLAN 1992-97, VOL. 1, at 9, ¶ 1.4.2 (ii) (1992). China's draconian measures to force a reduction in birth rates, including the one-child policy instituted in large parts of the country since 1979, have received much attention and praise from the international population establishment. For a discussion of the issues of coercion, population and fertility in China and India, see, e.g., JEAN DRÈZE & AMARTYA SEN, INDIA: ECONOMIC DEVELOPMENT AND SOCIAL OPPORTUNITY 57 (1995).

62. Feminists have pointed out that forcing women to have more children than they desire may be as harmful as coercive population control measures. Demographers have identified eleven governments that have explicit population growth strategies: Gabon, Iraq, Kuwait, Oman, Saudi Arabia, Cambodia, Korean Democratic Republic, Lao, Singapore, Taiwan and Uruguay. Pro-natalist ideologies have also influenced demographic policies in Chile, Argentina, Nicaragua and Guyana. In Singapore, the well-off, particularly ethnic Chinese are provided incentives to have more children. In Malaysia, ethnic Malays are encouraged to have more children than Indians and Chinese so as to strengthen the Islamic state religion and foster national "development." See CORRÊA & REICHMANN, *supra* note 56 at 40-43.

it considers unhealthy or undesirable populations.⁶³ Furthermore, the Cairo consensus notwithstanding, official family planning programs in developing countries continue to be seen as instruments of population control rather than as a means to enhance women's reproductive choice through principles of informed consent and respect for human dignity. With the existence of such programs, it is scarcely surprising that courts and legal systems in many developing countries that operate large-scale family planning programs often do not entertain suits that allege violations of human rights where the right violated is related to reproduction.⁶⁴

2. Economic Policies

In addition to state-sponsored population control programs, both international and domestic economic policies pose another institutional barrier to the attainment of reproductive choice and freedom. In recent years, many of the enabling conditions necessary for a realization of reproductive rights have been severely impaired by macro-economic policies such as structural adjustment that have been imposed by international financial institutions in several developing countries. Structural Adjustment Policies (SAPs), which require governments to reduce public sector expenditure, have contributed to the deterioration of public health systems in countries where the need for public services is the greatest. In its section on primary health and the health care sector, the Cairo Programme acknowledged that:

The impact of reductions in expenditures for health and other social services which have taken place in many countries as a result of public-sector retrenchment, misallocation of available health resources, structural adjustment and the transition to market economies has pre-empted significant changes in lifestyles, livelihoods and consumption patterns and is also a factor in increasing morbidity and mortality. Although economic reforms are essential to sustained economic growth, it is equally essential that the design and implementation of struc-

63. For example, state officials in communist Czechoslovakia forcibly sterilized Roman women to reduce the proportion of the country's 'unhealthy population.' China's 1994 law on maternal and infant health care undermines the right of couples with a 'serious hereditary disease' to found a family. THE HUMAN RIGHTS WATCH GLOBAL REPORT ON WOMEN'S HUMAN RIGHTS, *supra* note 8, at 410-11.

64. For example, a lawyer in Mexico who has represented women sterilized without their consent on several occasions, has reported that the petitions were refused every time by the agency of the Ministry of Public Justice. M. Teresita De Barbieri, *Gender and Population Policy*, in BEYOND THE NUMBERS: A READER ON POPULATION, CONSUMPTION AND THE ENVIRONMENT (Marge Berer trans.) *supra* note 6, at 262.

tural adjustment programmes incorporate the social dimension.⁶⁵

In addition to reductions in public expenditures, the simultaneous emphasis on privatization has encouraged the growth of health care without appropriate guarantees of universal access—a phenomenon that has not been adequately addressed or challenged even in the Cairo Programme of Action. Some women's NGOs, especially from countries of the South that are experiencing painful transitions to market economies, have criticized the Cairo document for its silence on issues of adjustment, debt, trade inequities and the practices of transnational corporations, all of which affect women's health, poverty and social programs. Two fundamental critiques emphasize the Cairo Programme's failure to challenge mainstream macroeconomic models and its failure to set forth mechanisms to ensure resource allocation, implementation and accountability.⁶⁶ Liberalization and privatization trends directly affect the health of girls and women by limiting access to health care through imposition of fees for services. Because women constitute the vast majority of the world's poor and rely overwhelmingly on state-supported social services, adjustment efforts place disproportionate burdens on them, as illustrated by a growing number of studies.⁶⁷

B. The Women's Convention and Government Practice

Although the Women's Convention remains the most comprehensive and evocative piece of treaty law in reproductive rights advocacy, no international human rights tribunal has applied it in any case.

65. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 55-56. For elaboration of the ways in which SAPs have impacted on women's health, well-being and livelihoods see UNEQUAL BURDEN: ECONOMIC CRISES, PERSISTENT POVERTY AND WOMEN'S WORK (Lourdes Beneria and Shelley Feldman eds., 1992); MALE BIAS IN THE DEVELOPMENT PROCESS (Diane Elson ed., 1991); MORTGAGING WOMEN'S LIVES: FEMINIST CRITIQUES OF STRUCTURAL ADJUSTMENT (Pamela Sparr ed., 1995).

66. See Rosalind P. Petchesky, *From Population Control to Reproductive Rights: Feminist Fault Lines*, 6 REPROD. HEALTH MATTERS 152 (Nov. 1995). See also, Betsy Hartmann, Cairo Consensus Sparks New Hopes, Old Worries (Summer 1997) (on file with the Forum for Applied Research and Public Policy).

67. For example, the maternal mortality rate in Tanzania in 1988, when structural adjustment efforts were in force, was four times that in previous years. The deaths were attributed to poor hospital conditions and shortage of blood, drugs and transport facilities, resulting from shrinking health sector spending under the adjustment regime. See Ulla Vuorela, *The Informal Sector, Social Reproduction, and the Impact of the Economic Crisis on Women*, in TANZANIA AND THE IMF: THE DYNAMICS OF LIBERALIZATION 109 (Horace Campbell & Howard Stein eds., 1992). A 1991 study in Zaire showed that structural adjustment's requirement of fees for service in all aspects of health care resulted in many more women being delivered at home. Caren Grown, *Structural Adjustment, Demographic Change and Population Policies: Some Preliminary Notes*, in THE STRATEGIC SILENCE: GENDER AND ECONOMIC POLICY 61, 64 (Isabella Bakker ed., 1994).

As a result, no test has been established to determine whether a law or practice offends the prohibition of all forms of discrimination against women.⁶⁸ This dearth of legal precedent or guidance renders the Women's Convention effective in theory but ineffective in practice.

For health advocates, an over-reliance on the Women's Convention is problematic for two reasons. First, its landmark provisions are undermined by the numerous reservations entered by ratifying states, many of them going against the very principle of non-discrimination.⁶⁹ Second, the Women's Convention is hobbled by the lack of an Optional Protocol which would authorize it to receive complaints from individuals, groups and organizations alleging violations.⁷⁰ In 1993, the Vienna World Conference on Human Rights agreed that existing mechanisms for implementation of women's human rights were inadequate and called for consideration of an Optional Protocol to place the Convention on an equal footing with other international human rights treaties that have complaint procedures. The 1995 Beijing Women's Conference also called for an Optional Protocol that would enter into force as soon as possible.⁷¹ There are no UN proce-

68. Cook, *supra* note 49.

69. As of 1997, a total of 156 nations had acceded to the Convention. As of 1995, 46 had made reservations to one or more articles. UNITED NATIONS, MULTILATERAL TREATIES DEPOSITED WITH THE U.N. SECRETARY-GENERAL, U.N. Doc. ST/LEG/SER.E/14 (author reviewed Dec. 31, 1995 version, for an update can be found on the internet at the United Nations website at http://www.un.org/Depts/Treaty/final/ts2/newsfiles/part_boov/iv_boov/iv_8.html). Reservations entered into by governments include Article 2 (commitment to eliminate discrimination); Article 5 (social and cultural patterns of conduct and family education); Article 9 (nationality and citizenship); Article 15 (legal status and equality before the law); Article 16 (marriage and family); and Article 29 (submitting disputes for arbitration). It is noteworthy that reserving countries span the spectrum of religions (from Iraq to Israel to India to Indonesia to Ireland to Italy) and political systems (from Austria and Australia to E Salvador, Bangladesh, Cuba and Cambodia). United Nations, *Declarations, Reservations, Objections and Notification of Withdrawal of Reservations Relating to the Convention on the Elimination of All Forms of Discrimination Against Women*, U.N. Doc. CEDAW/SP/1996/2 (1996).

70. The United Nations Commission on the Status of Women has noted that an Optional Protocol to the Women's Convention should include a communications and an inquiry procedure. It has pointed out that "an optional protocol would encourage States parties to make a major effort to comply with their treaty obligations resulting from the ratification of the Convention. A right to petition would also encourage compliance with the Convention in national legal systems and would provide guidance to States parties in their efforts to implement the Convention." UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON THE STATUS OF WOMEN, ADDITIONAL VIEWS OF GOVERNMENTS, INTERGOVERNMENTAL ORGANIZATIONS AND NON-GOVERNMENTAL ORGANIZATIONS ON AN OPTIONAL PROTOCOL TO THE CONVENTION, REPORT OF THE SECRETARY-GENERAL, at 5, ¶ 18, U.N. Doc. E/CN.6/1997/5 (1997) [hereinafter OPTIONAL PROTOCOL VIEWS].

71. UNITED NATIONS, REPORT OF THE WORLD CONFERENCE ON HUMAN RIGHTS, REPORT OF THE SECRETARY GENERAL, at 37, U.N. Doc. A/Conf.157/24(Part I)(1993); BEIJING

dures focusing on women's human rights that address individual cases or widespread violations with a view to providing remedies. For example, the mandate of the UN Special Rapporteur on Violence Against Women does not extend to the full range of rights protected by the Women's Convention. Nor can the UN Special Rapporteur determine remedies in individual cases or make recommendations in specific country situations.⁷²

Given these realities, women's health advocates have to devise creative alternatives to combat several entrenched family planning practices which contravene the Convention's prohibition of discrimination. One of the most pervasive forms of discrimination is on the basis of sex and marital status.⁷³ The official family planning programs in most developing countries serve the demographic and administrative category of MWRA (married women of reproductive age). Single or unmarried women and adolescents are denied these services on principle or in practice. Furthermore, in many countries, family planning programs require women, and not men, to obtain spousal authorization for contraceptive services.⁷⁴ In others, sterili-

PLATFORM FOR ACTION, *supra* note 11, at 97. An in-session working group of the Commission on the Status of Women, in accordance with Commission resolution 40/8 of 22 March 1996, elaborated upon and produced a first reading of a draft Optional Protocol during the Commission's 41st session held in New York from March 10 to 21, 1997. The working group considered statements from 18 governments and 19 non-governmental organizations and found large support for an Optional Protocol as a means to strengthen the Convention. See OPTIONAL PROTOCOL VIEWS, *supra* note 70, at 4-5. At present, four major UN human rights treaties provide for communications procedures either in a separate Optional Protocol or as part of the treaty itself. See Optional Protocol to the International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966; CERD, *supra* note 43, at Art. 14; Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment, *adopted* Dec. 10, 1984, 1465 U.N.T.S. 85 at Art. 22; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, *adopted* Dec. 18, 1990, G.A. Res. 45/158, U.N. GAOR, 45th Sess., Supp. No. 49 at 261, 272, Art. 77, U.N. Doc. A/45/49 (1991).

72. The U.N. Commission on Human Rights, at its 50th session in March 1994, decided to appoint, for a three-year period, a Special Rapporteur on violence against women, its causes and consequences. The Special Rapporteur was to report to the Commission on an annual basis. In her 1996 report on all forms of violence against women in the family, the Special Rapporteur noted that only 44 States had replied to the UN Secretary-General's request to all UN member nations to assist her in her tasks by providing all information and data requested. She also noted that the government of the United Arab Emirates had disregarded her communication on the flogging of a 16-year-old migrant Filipina worker who had stabbed her employer to death in self-defense after he had raped her at knife-point. SPECIAL RAPPORTEUR REPORT, *supra* note 57, at 4-5.

73. [T]he term 'discrimination against women' shall mean any distinction, exclusion or restriction made on a basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. Women's Convention, *supra* note 35, at Art. 1.

74. Cook & Haws, *supra* note 38, at 50. See also, Rebecca J. Cook & Deborah Maine,

zation is performed only for health reasons and is made conditional on the number of cesarean sections a woman has undergone. In such instances, principles of non-discrimination would require that sterilization be offered to the husbands of women who have had cesarean sections, both to equalize access and to more evenly distribute between men and women the risks, costs, and duties of avoiding pregnancy.⁷⁵ A vasectomy is a much simpler, safer, and less expensive procedure than a tubectomy. Unfortunately, this shifting of burdens rarely takes place. Rather, women are overwhelmingly the targets for contraception in family planning programs in which they bear the burden and the responsibility for limiting family size, yet lack any autonomy or control in decision-making.⁷⁶

The above discussion illustrates the nature and power of the host of forces reproductive health advocates have to confront and negotiate within the struggle for reproductive rights. The struggle for reproductive choice and freedom is inextricably linked with other ongoing struggles for gender awareness and gender justice in macro-economic policies such as structural adjustment and for greater recognition and protection of women's human rights by international bodies and national mechanisms. Most importantly, the struggle for reproductive rights is a challenge to the imperial authority of the global population 'establishment' and to patriarchal controls over women's autonomy by governments the world over – facts that are starkly evident in the demographically-driven practices of family planning programs.

Superficially, reproductive rights advocates' goals of greater contraceptive choice and freedom are similar to those of the population establishment and state-run family planning programs in individual countries. For both, however, women are a means to an end, namely, fertility reduction, and therefore objects of control rather than agents of freedom. Both these entities will support tenets of reproductive choice and freedom only so long as they do not jeopardize the societal goal of population control or challenge the larger social order

Spousal Veto Over Family Planning Services, 77 AM. J. OF PUB. HEALTH 339 (1987).

75. Cook & Haws, *supra* note 38, at 50-51. One example of the arbitrary mathematical formulas that are applied is the 'rule of 80,' which allows a woman to be sterilized only when the number of her living children multiplied by her age exceeds eighty.

76. "Women's fertility has been the primary object of both pro-natalist and anti-natalist population policies. Women's behavior rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as public policy. Sexuality and gender-based power inequities have been largely ignored, and sometimes even strengthened, by population and family planning programs." *Women's Declaration on Population Policies*, in POPULATION POLICIES RECONSIDERED: HEALTH, EMPOWERMENT, AND RIGHTS 31, 32 (Gita Sen et al. eds., 1994).

premised on women's subservience and adherence to prescribed roles in the family and community. The perceived threat to the social order from women's sexual freedom is one reason why human rights, with its upholding of individual rights rather than collective obligations, becomes explosive when applied to women's reproduction and sexuality.⁷⁷ Issues of reproductive and sexual autonomy possess valuable political currency in any society. This reality, along with institutional barriers and the problems of recourse under national and international legal instruments, raises a third and more profound difficulty for advocacy: the limitations imposed by "rights" language itself.

III. THE LIMITATIONS OF "RIGHTS" APPROACHES

A woman's ability to bear children is linked to the continuity of families, racial and ethnic lineage, the perpetuation of social groups and classes, the control of property, the relationship between men and women, and the expression of sexuality. Women's reproductive capacity is imbued with potent symbolism in all religious traditions and systems and has therefore always been targeted for control by families and religious institutions.⁷⁸

A women-centered approach to reproductive health seeks to dismantle these controls. Fundamentally, such an approach is about trusting women and granting them the authority and the ability to make reproductive decisions based on adequate information and services.⁷⁹ The Cairo Programme of Action represents a challenge to patriarchal structures in the family and society with its focus on women's empowerment as a key to several goals: full participation in the development process,⁸⁰ healthy and fulfilling lives,⁸¹ the realization of full human potential for women and the girl-child,⁸² and enhanced decision-making capacity at all levels and in all spheres of life, especially in the area of sexuality and reproduction.⁸³ The prospect evokes unease and outright opposition from families, states and other centers of male authority, prompting a range of countervailing measures.⁸⁴

77. See, e.g., Fatima Mernissi, *Femininity As Subversion: Reflections on the Muslim Concept of Nushuz*, in *SPEAKING OF FAITH: GLOBAL PERSPECTIVES ON WOMEN, RELIGION AND SOCIAL CHANGE* 95 (Diana L. Eck & Devaki Jain, eds., 1993).

78. Deborah Maine, et al., *Risks and Rights: The Uses of Reproductive Health Data*, 6 *REPROD. HEALTH MATTERS* 40, 40 (Nov. 1995).

79. Freedman & Isaacs, *supra* note 23, at 19.

80. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 28, ¶ 4.15, & 25, ¶ 4.2.

81. *Id.* at 25, ¶ 4.1.

82. *Id.* at 28, ¶ 4.15 & 26, ¶ 4.3.

83. *Id.* at 25, ¶ 4.1.

84. At the Cairo conference, the Holy See entered a reservation on the entire Chapter VII of the Programme of Action, relating to reproductive rights. It also placed a reserva-

Beyond the dry data on fertility trends and lofty formulations of rights, are women and men, sex and procreation, and social customs and expectations. When trying to control their fertility, women are confronted with a host of issues, such as power struggles between the sexes, the hierarchical relations between health providers and clients and between the state and its people. Without a full and sensitive understanding of these realities, in specific countries and cultures, neither population debates nor the assertion of universal reproduction rights can be meaningful. Reproductive behavior is more heavily influenced by systems of gender relations, economic constraints, group norms, and community and family expectations than by the position or desire of individual women.⁸⁵ This is especially true in cultures where women lack fundamental rights, where they are still trapped within traditional milieus which assign a very high value to child-bearing and little value to anything else, and where poverty and insecurity make children an economic necessity.⁸⁶ Furthermore, women's economic and social dependence on men prevents them from asserting their rights.

Advocacy efforts that are founded on western notions of human rights, with their abstract individualism, quickly flounder in a domain as charged as human reproduction. They raise antagonistic dichotomies such as North-v.-South, West-v.-East, Orthodox Christianity or "fundamentalist" Islam v. liberal secularism, the family v. "feminazis," the individual vs. the collective, civil and political v. economic and social rights, and so on. Underlying such dichotomies, whether raised by the Vatican, the religious right in the U.S., the Islamic clergy, or centers of male authority, is the fear that the empowerment of women means the disempowerment of men, and that women's rights can only exist in opposition to the collective, be it the home, the family, the community, or the nation.⁸⁷ This fear of and opposition to agendas

tion on the entire Section C of Chapter IV, relating to health, in the Beijing Platform for Action, on grounds that "[t]his section devotes a totally unbalanced attention to sexual and reproductive health in comparison to women's other health needs." BEIJING PLATFORM FOR ACTION, *supra* note 11, at 163, ¶ 11.

85. RUTH DIXON-MUELLER, *POPULATION POLICY AND WOMEN'S RIGHTS: TRANSFORMING REPRODUCTIVE CHOICE* 109-39 (1993).

86. In Iran, women often prefer to have three or four children in the hope that a larger family would reduce the likelihood of their husbands marrying again and taking on additional financial responsibilities. In the event of a divorce, it is harder for men to take away the children when there are more than one or two. Women set their own fertility goals (even secretly discontinuing contraceptives) to safeguard their interests. Homa Hoodfar, *Bargaining With Fundamentalism: Women and the Politics of Population Control in Iran*, 8 *REPROD. HEALTH MATTERS* 30, 36-37 (Nov. 1996).

87. For example, Pat Robertson, leader of the Christian Coalition in the United States, is on record as stating that, "[t]he feminist agenda is not about equal rights for women. It is a socialist, anti-family political movement that encourages women to leave their husbands, kill their children, practice witchcraft and become lesbians." Maralee Schwartz &

for women's empowerment is a common thread uniting the fundamentalist forces in all religions, who style themselves as the guardians of purity, tradition, and moral values.⁸⁸ By provoking such adversarial stances, sometimes albeit unintentionally, rights advocates contribute to a representation of the issues in such a way as to make women, across cultures, choose values that are deemed "traditional" or appropriate over those that assert individual rights.⁸⁹ Far from empowering women, the rights discourse can then have precisely the opposite impact, perpetuating the subordination and manipulation of women by patriarchal ideologies and systems, whether in the political establishment, the religious right, or within the community.

A. Rights vs. Local Norms and Cultures

Indonesia provides an instructive example of how rights-based advocacy in reproductive health can work against the interests of women. The Indonesian state-sponsored family planning program, which has been in place since 1970, has achieved what international population agencies describe as one of the most impressive demographic transitions in the developing world. This feat has tended to obscure the program's strong target orientation, paternalistic approach, and subtle and overt forms of government coercion.⁹⁰ The

Kenneth J. Cooper, *Equal Rights Initiative in Iowa Attacked*, WASH. POST, August 23, 1992, A15.

88. The objections of some prominent Islamists to the Cairo conference mirrored those of the Vatican and included allegations that the Cairo Programme of Action ignored religion and sacred values, encouraged destruction of the family, prevented parents from acting as guardians of their children, and permitted adultery and abortion. Both Islamists and the Vatican described the Beijing Platform for Action as "western" and said that the demand for equality between men and women was tantamount to encouraging conflict between them and destroying the family. Amal Abd El-Hadi, *Islamic Politics in Beijing: Change of Tactics But Not Substance*, 8 REPROD. HEALTH MATTERS 47, 49 (Nov. 1996). Hindu nationalist leaders in India have similarly expressed themselves against "[t]oo much freedom to women [which] would break the nuclear family . . ." Ratna Kapur & Brenda Cossman, *Communalising Gender, Engendering Community: Women, Legal Discourse and the Saffron Agenda*, in WOMEN AND THE HINDU RIGHT 82, 98 (Tanika Sarkar & Urvashi Butalia eds., 1995). After the Nairobi women's conference, the women's wing of the far-right Hindu nationalist Bharatiya Janata Party, said the conference's demands for the evaluation of women's domestic work in terms of money was an "insult to Indian motherhood" and "legal sanction of lesbianism too vulgar and irrelevant in the Indian context." *Id.* at 99 (noting that wages for housework and lesbianism undermine women's natural roles as wives and mothers and therefore cannot be supported).

89. See, e.g., Charlesworth *et al.*, *supra* note 44, on the ways in which demands of national, racial and ethnic identity can obscure women's common experiences of subordination and blunt their challenge to patriarchal structures of male domination. At the Beijing women's conference, Islamist women's associations from different countries were a strong and organized presence, often acting in concert with western conservative forces, notably the Vatican, to condemn the conference document. El-Hadi, *supra* note 88, at 48.

90. *The World Bank Staff Appraisal Report, Fifth Population Project, cited in IN THE NAME OF DEVELOPMENT: HUMAN RIGHTS AND THE WORLD BANK IN INDONESIA* (A Joint Re-

program's success in bringing down the birth rate has also helped Indonesia evade censure for the fact that its maternal mortality rate of 450 per 100,000 live births is among the highest in the world.⁹¹

During and after the 1994 Cairo Conference on Population and Development, the country's powerful population establishment, and in turn the media, projected the Cairo Programme a "West-oriented" initiative that promotes abortions, free sex, and homosexual marriage. Indonesia, as a leader among developing countries, is said to have played a dominant role at Cairo, joining forces with other Southern countries to "oppose areas promoted by the West, especially abortion and gay rights."⁹² Indonesian leaders also claim credit for framing the umbrella statement of principles of national sovereignty opening Chapter II of the Cairo Programme of Action.⁹³ Indonesia's statement asserting its national sovereignty, backed by many developing countries, is an expression of what has come to be known as "Asian values." Such values refer to the primacy of community, family, and religious norms over an individual's rights. Governing elites in many non-western societies, including Africa, invoke these values to counter western notions of human rights and feminism that they consider inappropriate to their cultures.

Several commentators and NGOs in Indonesia have interpreted the government's approach to the Cairo Programme of Action as a masterly strategy that achieves several purposes simultaneously. On the one hand, the appeal to "Asian values" legitimizes the government's intention to continue implementing population policies with minimal orientation to Cairo principles. On the other hand, by thus distancing itself from the "immoral" practices of the West, the gov-

port of the Lawyers' Committee for Human Rights and the Institute for Policy Research and Advocacy)(1995). The Indonesian program, instituted in 1970, has relied heavily on a system of incentives and disincentives, both for users and providers of contraceptive services, and ranking of provinces according to methods used, to fulfill state-determined targets for fertility reduction. "Safaris," or mass campaigns to recruit family planning acceptors, often with the help of the armed forces, have been a key component of the program. For a documentation of coercive practices in the Indonesian program, see *id.* at 116-30. See also BETSY HARTMANN, *REPRODUCTIVE RIGHTS AND WRONGS: THE GLOBAL POLITICS OF POPULATION CONTROL* (1995); Terence J. Hull et al., *Indonesia's Family Planning Story: Success and Challenge*, 32 *POPULATION BULL.*, November 1977, at 3, 33.

91. UNITED NATIONS DEVELOPMENT PROGRAM, *HUMAN DEVELOPMENT REPORT* 158 (1996).

92. Excerpt from interviews in Jakarta for a preliminary survey on post-Cairo population policies in the Asia-Pacific (1995)(conducted for the Kuala Lumpur-based Asian-Pacific Resource and Research Centre for Women ARROW).

93. "The implementation of the recommendations contained in the Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights." *CAIRO PROGRAMME OF ACTION*, *supra* note 2, at 14.

ernment appeases the powerful Majelis Ulama Indonesia and other powerful Islamic organizations whose views on modern family planning methods, abortions, and adolescent sex education and counseling influence the conduct of the official family planning program.⁹⁴

However, given the political consensus on the need for population stabilization, the Indonesian government does not prevent non-government and private health facilities from offering any of these services.⁹⁵ At the same time, the political interest in keeping religious revivalism at bay necessitates a cautious approach that falls short of granting a right to abortion and adolescent contraception. Advocacy strategies rooted in notions of universal rights run the risk of putting policy-makers on the defensive, confounding the work of NGOs in the field, and making women the ultimate losers. Finally, the government's negative portrayal of reproductive rights has had the effect of inhibiting women's groups who fear being compromised as agents of western imperialism.⁹⁶

Such hostile responses to human rights principles seen as emanating from the West are not unique to Indonesia. In countries where there are similar taboos on adolescent and extra-marital sex and where governments are less pragmatic, rights-oriented strategies can prompt even narrower interpretations of religion and custom in direct response to what are characterized as "alien" values of western feminism and individualism.

An unqualified recourse to rights language is problematic for advocacy in two other ways. First, it allows states to pay lip service to women's right to reproductive health while opposing all substantive policies that will enable them to realize that right. Thus, the Vatican can express its "commitment" to the promotion of the health of women and girl children and the prevention of maternal mortality, while opposing all forms of contraception, abortions and the right of women to control their sexuality.⁹⁷ Other countries have made similarly vague affirmations of rights while failing to undertake specific

94. For example, conservative sections of the Islamic clergy frown upon the promotion of the condom as a family planning method and as a protection against AIDS since it implies and condones extra-marital sex on the part of married men. Leaders belonging to the Muhammadiyah, an independent modernist organization, have emphasized the importance of "traditional family values" and are strongly opposed to condoms and sex education, which they see as signs of promiscuity and defiance of divine law. See Rosalia Sciortino et al., *Learning From Islam: Advocacy of Reproductive Rights in Indonesian Pesantren*, 8 REPROD. HEALTH MATTERS 86, 88 (Nov. 1996).

95. The Indonesian Planned Parenthood Association and the Yayasan Kusuma Buana are two NGOs that supplement government efforts through women-centred reproductive health services, adolescent counseling, and so on, see, *supra* note 92.

96. See *supra* note 92.

97. BEIJING PLATFORM FOR ACTION, *supra* note 11, at 163.

responsibilities to ensure their realization.⁹⁸ Through such a selective upholding of rights, states can keep intact fundamentally discriminatory policies on the grounds of defending their rights to state sovereignty and to the maintenance of local norms and cultures.

In addition to perpetuating empty promises, a purely rights-oriented approach can lead to generalized linkages between causes and reproductive health outcomes and to a disregard for critical data, both having serious implications for policies and programs and for women's lives. For example, the right to modern contraceptive services is seen as instrumental in reducing pregnancy, spacing births, and safeguarding the health of women. Focusing solely on the realization of this right can obscure the fact that a one percent failure rate in a contraceptive method used by a million women can result in a thousand unwanted pregnancies each year.⁹⁹ In countries where abortion is illegal, unsafe, or a source of stigma and shame for women who seek them, and where quality obstetric services are absent, contraceptive failures can be fatal for large numbers of women. Furthermore, even in countries where birth control is generally accepted, women's access to contraceptives is complicated by their life circumstances. Violence, sexual victimization, and fears of desertion and accusations of infidelity can prevent women from exercising reproductive and sexual autonomy.¹⁰⁰

B. Rights in the Context of Maternal Mortality

The ways in which "rights" language can lead advocacy strategies off course is most apparent in the problem of maternal mortality. Health advocates cannot afford to let this happen because maternal mortality is a particularly sensitive indicator of inequity. "[It] is a litmus test of the status of women, their access to health care, and the adequacy of the health care system in responding to their needs."¹⁰¹ The phenomenon of maternal mortality has reached tragic proportions

98. See, for example, the reservations entered by Indonesia, Iran, Iraq, Kuwait, Libya, Malaysia, and Malta in the Beijing document. BEIJING PLATFORM FOR ACTION, *supra* note 11, at 65-70. The criminalizing of abortion leads to unsafe abortion, which is a major cause of maternal morbidity and mortality. WHO estimates that globally, 20 million unsafe abortions are performed each year, resulting in the death of 70,000 women. Illegal abortion and the incidence of unsafe abortion is highest in South America, where abortions deaths represent one-fourth of total maternal mortality. Women under twenty account for twenty-five per cent of all abortions in Malaysia. UNITED NATIONS, THE WORLD'S WOMEN 1995: TRENDS AND STATISTICS, *supra* note 5, at 79.

99. Maine et. al., *supra* note 78, at 44.

100. LORI L. HEISE ET AL., VIOLENCE AGAINST WOMEN: THE HIDDEN HEALTH BURDEN 17-19 (World Bank Discussion Paper No. 255, 1994).

101. *Pregnancy and related deaths*, THE EARTH TIMES, Mar. 15, 1996, at 2 (quoting Dr. Susan Holck of WHO's Reproductive Health Program).

in developing countries.¹⁰² A staggering 585,000 women worldwide die every year due to complications associated with pregnancy and childbirth.¹⁰³ Ironically, maternal aspects of health have always received secondary priority in official maternal and child health programs.

A rights-oriented strategy to deal with maternal mortality is premised on the assumption that the fewer the number of births, the fewer the number of maternal deaths. Thus, this strategy assumes that women's right to family planning and contraceptive services is key to decreasing maternal mortality. It is true that access to contraceptive services for women who want to limit family size can reduce maternal mortality substantially, by fifteen percent in Sub-Saharan Africa to forty percent or more in parts of South Asia. However, contraceptive access is only a partial solution to the problem of maternal mortality because it does not reduce deaths among pregnant women.

In the absence of other services to deal with pregnancy, specifically emergency obstetric care, women are just as likely to die once they get pregnant. The major causes of maternal deaths in developing countries today are the same as they were in industrialized countries fifty years ago—sepsis (infection), hemorrhage (internal bleeding), eclampsia (convulsions), and obstructed labor. Ten studies in developing countries showed that at least seventy-five percent of all obstetric deaths were attributed to these causes.¹⁰⁴ Even in countries such as Bangladesh and India where abortion is legally permissible on health grounds, community studies have found that fifteen to twenty-four percent of all maternal deaths are due to abortions.¹⁰⁵

These statistics show that any serious attempt to reduce maternal deaths must go beyond merely guaranteeing women the rights to contraceptive services and abortions: it must create conditions to enable women to realize these rights. The social stigma of having a child outside of marriage further complicates women's abortion deci-

102. A woman's lifetime risk of maternal death, which is the average cumulative likelihood that she will die of a maternal cause, is 1 out of 23 women in Africa, 1 out of 54 in Asia and 1 out of 73 in Latin America. Lynn P. Freedman & Deborah Maine, *Facing Facts: The Role of Epidemiology in Reproductive Rights Advocacy*, 44 AM. U.L. REV. 1085, 1090 (1995). By contrast, it is 1 out of 10,000 women in Northern Europe. *Id.* The World Health Organization estimates that in half the developing countries, maternal mortality is the first or second most common cause of death among women twenty-five to thirty-four years old. In the rest, it is in the top ten. THE WORLD BANK, POPULATION AND DEVELOPMENT: IMPLICATIONS FOR THE WORLD BANK (1994).

103. *Pregnancy related deaths*, *supra* note 101.

104. Allan Rosenfield & Deborah Maine, *Maternal Mortality - A Neglected Tragedy: Where is the M in MCH?*, THE LANCET, July 13, 1985, at 83, 84.

105. Maine et. al., *supra* note 78, at 44.

sions, forcing many of them to resort to unsafe and often fatal methods to end the pregnancy. In other words, the gulf between *legal* access and *social* access to abortion is very wide in many parts of the developing world and is an indicator of the shortcomings of purely rights-oriented approaches in this area.

In addition to contraceptive access, the right to education is often seen as a causal factor in reducing maternal and infant mortality. Several studies do indeed show that the higher the level of women's education, the greater their use of modern medical services.¹⁰⁶ However, focusing on education as a key factor in reducing maternal mortality lets the health system off the hook.¹⁰⁷ It obscures institutional factors, such as quality, accessibility and affordability of services, and socio-cultural barriers between user and provider that deter women from using these services and pose real obstacles to the realization of reproductive health. Women's right to education is an important goal in itself, and undoubtedly raises their awareness of good health practices. Nevertheless, it clearly cannot be a substitute for good health services, the provision of which is a separate, positive obligation of the state.

The literature on the actual correlation between education and infant and maternal mortality provides further illustration of the faulty focus of a purely rights-oriented approach in reproductive health. In countries such as Cuba, China, Costa Rica, and Sri Lanka, infant mortality declined independent of education. In others, neither strong national investments in education nor the achievement of a high literacy rate appears to have had any effect on high maternal mortality rates. Paraguay and Tanzania are examples of countries that *combine* high literacy rates with high maternal mortality rates.¹⁰⁸ In the United States in 1915, when more than 90 per cent of women were already literate, maternal mortality was still over 600 per 100,000 births.¹⁰⁹

Maternal mortality cannot, therefore, be attributed singularly to a denial of access to contraceptives or education. Rather, it is a complicated combination of life circumstances, embedded gender bias in society, and institutionalized systems of neglect which can be blamed for the deaths of millions of women during childbirth. Even a broad-based human rights approach does not go to a crucial aspect of the problem: the failure of public health systems in developing countries

106. Sereen Thaddeus & Deborah Maine, *Too Far To Walk: Maternal Mortality in Context*, 38 SOC. SCI. MED. 1091, 1099 (1994).

107. *Id.*

108. *Id.* at 1100. Paraguay's adult literacy rate is eighty-five percent and its maternal mortality rate is 469/100,000. Tanzania's adult literacy rate is eighty percent, but its maternal mortality rate is similarly high at 370/100,000. *Id.*

109. Freedman & Maine, *supra* note 102, at 1091.

to tackle the many preventable causes of maternal mortality. Rights are worth very little in the context of maternal mortality unless there are specific duties and obligations on the part of governments, such as a major investment in a system of comprehensive maternity care. This is not beyond the means of most countries provided there is a dramatic shift in priorities.¹¹⁰

C. Practical Approaches in Advocacy

While negotiating the minefield of reproductive rights territory, women's health advocates will find their goals better served if they concentrate their energies on practical, results-oriented strategies rather than rights-based approaches. Such results-oriented strategies serve several purposes at once in reproductive health advocacy. First, they create a neutral and unproblematic space in which to hold governments accountable to their commitments to women's health. This commitment entails making health service delivery more responsive to women's needs and calls for systemic changes in health facilities and attitudinal changes in staff that will benefit users as a whole. Second, by raising demands for concrete outcomes, reproductive health advocates can hold the spotlight on government actions. Under sustained scrutiny, governments will not be able to disregard their commitments so easily. Rather, they will be compelled to take action and to desist from negotiating and re-negotiating "rights" language—a tactic which enables them to keep their commitments at the level of rhetoric. Finally, given the daunting economic, political, and social forces with which women's health advocates must contend, results-oriented approaches lend clarity, focus, and purpose to reproductive health agendas.

To enable advocates to overcome the general lack of specificity in the Cairo Programme of Action and help governments prioritize reproductive health tasks, some commentators have isolated a 'minimum core content' in the Cairo document.¹¹¹ Such a core package would encompass, among others, family-planning counseling, information, education, communication and services, pre-natal and post-natal care, especially breast-feeding and infant and women's health care, and treatment of reproductive tract infections and sexu-

110. In fact, it has been argued that the collective right to life of women in groups at high risk of maternal mortality or morbidity calls for a positive obligation by states to make available appropriate reproductive health services to them or, at the very least, education and counseling services to inform them of risks and how to minimize risk. See Rebecca J. Cook, *International Human Rights and Women's Reproductive Health*, in *WOMEN'S RIGHTS, HUMAN RIGHTS: INTERNATIONAL FEMINIST PERSPECTIVES* 256 (Julie Peters & Andrea Wolper eds., 1995).

111. Rahman & Pine, *supra* note 59, at 406-9.

ally transmitted diseases.¹¹² Clearly, there is vast scope for practical advocacy strategies within this core area alone. Under human rights law, it is the responsibility of nations to ensure minimum essential levels of access to reproductive health in a non-discriminatory manner. Both the Women's Convention and the Economic Covenant support the legal basis of this claim.¹¹³

Integral to efforts to improve the provision of services is quality of care. Quality of care has emerged as a central concern in sections of the international population establishment, with several research efforts aimed at demonstrating the impact of improved quality of services on fertility reduction. Quality of care also lies at the heart of the international women's health and rights agenda for different reasons, mainly because it shifts the perspective from the provider to the client, making women the subjects, not the objects of population policies. Advocacy strategies that start with a health perspective and focus on improving the quality of reproductive health care in public services will go a long way in reconciling the inherent tensions between the demographic and health objectives of family planning programs.

Most family planning programs are currently evaluated on the basis of their *quantitative* impact on fertility, through indicators such as contraceptive prevalence and number of births averted. Quantitative impact also represents the reason for support of these programs by major donor agencies. Despite the rhetorical consensus among governments on the importance of quality of care,¹¹⁴ principles of quality may be difficult to implement in conventional, demographically-driven family planning programs, unless it can be shown that improvements in quality result in an increase in contraceptive use and a reduction in fertility.¹¹⁵

To transform family planning programs to reflect reproductive health concerns, it is therefore necessary to evolve indicators that will

112. CAIRO PROGRAMME OF ACTION, *supra* note 2, at ¶ 7.6

113. Women's Convention, *supra* note 35, at Art. 12(1); ICESCR, *supra* note 13, at Art. 2 (requiring governments to "achiev[e] progressively" the right to health set forth in Article 12).

114. See CAIRO PROGRAMME OF ACTION, *supra* note 2, at 47, ¶ 7.14, endorses the six quality of care principles developed by international family planning experts: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and the appropriate constellation of services. For a full discussion of the quality of care framework, see Judith Bruce, *Fundamental Elements of the Quality of Care: A Simple Framework*, 21 *STUD. IN FAM. PLANNING* 61 (1990).

115. The results of studies in five countries, Taiwan, South Korea, Thailand, Hong Kong, and India, and of a research project in Matlab, Bangladesh, have shown that broadening contraceptive method choice demonstrably increased contraceptive prevalence. Anrudh K. Jain, *Fertility Reduction and the Quality of Family Planning Services*, 20 *STUD. IN FAM. PLANNING* 1 (1989).

evaluate programs on the basis of their *qualitative* impact, and demonstrate that integrating quality of care principles does not hinder program performance in fertility control. There is now increasing attention in the international population field to the task of creating alternative indicators to ensure, as well as measure, the reproductive health content of family planning programs.¹¹⁶

Reproductive health strategies also have to overcome other common reservations expressed by family planning program managers and policymakers about the integration of quality of care principles. Some of these concerns are that comprehensive health services are too expensive to contemplate in resource-poor, high-fertility countries and that family planning services are overburdened and cannot handle expanded service demands.¹¹⁷ Although the concern over resources is real, most programs can find cost-effective and efficient means to monitor the performance of field staff and facilities in addressing the reproductive health concerns of clients. For example, health advocates can urge governments to impose reporting requirements on education, training and the last re-training of clinical staff, availability of clean toilets and running water at primary health centers, the presence of equipment for sterilization of instruments, and the degree of privacy given to clients. Some of these methods to create a climate for quality concerns are already in place in well-run family planning programs in Latin America.¹¹⁸

Because there are remedies to allay the concerns over resources, keeping a watch on the direction and nature of population expenditure by monitoring national budgets and international funding flows is another key aspect of results-oriented reproductive health advocacy strategies. This type of financial monitoring is imperative for two

116. WHO, for example, has developed indicators specific to maternal health, such as annual numbers of maternal deaths and maternal mortality ratio, proportion of women attended by trained personnel at least once during pregnancy, proportion of complicated obstetric cases managed at specific facilities, and so on. Rahman & Pine, *supra* note 59, at 415 (citing World Health Organization, *Indicators to Monitor Maternal Health Goals: Report of a Technical Working Group* (1993)). One new measure proposed by the World Bank is a dropout ratio to gauge user reactions to family planning services. RODOLFO A. BULATAO, KEY INDICATORS FOR FAMILY PLANNING PROJECTS 12 (World Bank Technical Paper No. 297, 1995). The figure is derived by excluding all those who intentionally discontinue using a contraceptive method (to adopt another or to have a child), to represent those who stop using contraception for fear of side-effects, non-availability, cost, spousal opposition, inconvenience, or other reasons that can be remedied through better service provision and counseling. *Id.*

117. Christopher J. Elias, *A Puzzle of Will: Responding to Reproductive Tract Infections in the Context of Family Planning Programs*, REPRODUCTIVE HEALTH APPROACH TO FAMILY PLANNING (The Population Council, 1994).

118. John C. Ickis, *Quality of Family Planning Services in Latin America: Regional Overview*, in MANAGING QUALITY OF CARE IN POPULATION PROGRAMS 67 (Anrudh K. Jain ed., 1992).

reasons. The first is to gauge the actual extent of resource constraints among governments.¹¹⁹ Second, the prevailing reproductive health language often only thinly conceals the "population control" mindset that persists among policy-makers in international donor institutions and in donor countries. Such an outlook defines the conduct and parameters, and thereby the reproductive health and human rights components of family planning programs in developing countries.

Following the Cairo conference, some non-governmental organizations have started to focus on these concerns through advocacy initiatives in collaborative accountability, which are premised on partnerships between health advocates in different countries working to hold their respective governments accountable to them. For example, health advocates in donor countries of the North monitor their governments' international population assistance to ensure that funding is contingent on reproductive health criteria in family planning programs in developing countries. Similarly, health advocates in the South watch the conduct of these programs to hold their governments accountable to commitments of reproductive health principles.¹²⁰ Such collaborative efforts are also a means of realizing the objectives laid out in Chapter XIV of the Cairo Programme of Action: strengthening policy dialogue at the international level; fostering capacity-building;

119. The international donor community, charged with shouldering \$5.7 billion (one-third of the estimated \$17 billion required by the year 2000) to implement the Cairo Programme of Action, had mustered only \$2 billion by 1995. The UN Commission on Population and Development noted at its 30th session in February 1997: "Although several donor countries have shown early and laudable commitments through announcements of increased funds for population activities, overall official development assistance has declined in recent years. . . . To realize the concrete and achievable goals clearly set out by the conference, the mobilization of resources must be placed high on the global development agenda, and the implications of increasing financial resources . . . as called for in the Programme of Action, must be faced squarely." FOLLOW-UP ACTIONS, *supra* note 60, at 26-27. In the U.S., a conservative majority in the House of Representatives slashed the U.S. contribution to the United Nations Population Fund by \$13 million, from \$35 million in 1995 to \$22 million in 1996. *U.S. Congress Cripples 1996 Fiscal Year Aid for Family Planning*, 18 POPLINE, WORLD POPULATION NEWS SERVICE (Jan.-Feb. 1996). See also, THE ALAN GUTTMACHER INSTITUTE, *Endangered: U.S. Aid for Family Planning Overseas*, ISSUES IN BRIEF (1996).

120. For example, the Health and Development Policy Project, a Washington-based not-for-profit organization, is developing a series of case studies exploring the application of health and human rights principles within the population policies of specific countries. One, in the state of Uttar Pradesh, India, seeks to analyze demographic trends, reproductive health and reproductive decision-making in this state, with a focus on U.S. population assistance to India. A second case study examines population policy and reproductive rights in Mexico. Both seek to assess the degree of compliance by governments and donor agencies with the objectives of health and human rights in population policies set forth in the Cairo and Beijing platforms. THE HEALTH AND DEVELOPMENT POLICY PROJECT, PROPOSAL TO THE SUMMIT FOUNDATION (1997) (Takoma Park, MD).

and transferring technology and know-how at the program level.¹²¹

In addition to collaborative accountability, reproductive health advocates use tribunals as an effective way to record women's experiences of violence at home or at the hands of the state, of callous neglect and disregard of their bodies and sexuality in government-sponsored population control efforts.¹²² Tribunals enable contextualized inquiries and make women's voices heard and heeded. They also shed light on whose values and whose points of view actually determine child-bearing decisions, and are thus an integral part of the health and human rights agenda.¹²³ Tribunals help bridge the divides of culture, class, community and nation, upholding women's common humanity while respecting the very different realities and circumstances in which women experience sexuality and motherhood. Most importantly, they help overcome the assumption of personal responsibility in reproductive decisions. Such unilateral action is problematic not only because its abstract individualism carries little appeal in non-western cultures, but because it ignores the ways in which women's social and economic contexts influence reproductive decisions. Finally, tribunals can prevent states, organizations and individuals from ignoring their obligations and require them to ensure conditions for the exercise of reproductive rights.

CONCLUSION

The articulation of a right to health and reproductive health and the clear textual support for it, leave us a long way from the realization of this international human right. International rights discourse

121. CAIRO PROGRAMME OF ACTION, *supra* note 2, at 102, ¶¶ 14.3 (e) & 14.4.

122. During the Women's conference in Beijing, women's activists held tribunals and hearings at the NGO Forum, detailing the many violations that women suffer, such as violence in war and conflict, violence in the family, violations of bodily integrity and health rights, violations of the rights of migrant, refugee, displaced, marginalized and disabled women. Alda Facio, *What Will You Do? - Women's Human Rights, Excerpts, Statement by the Center for Women's Global Leadership, 13 September 1995*, 24 WOMEN'S STUD. Q., 66, 67 (1996).

123. For example, a study by the International Reproductive Rights Research Action Group (IRRRAG) in seven nations and four continents documents women's own perceptions of their rights and responsibilities in fertility behaviour. Two NGOs in Indonesia, Yayasan Kusuma Buana and the Women's Studies Graduate Program of the University of Indonesia, launched programs in 1996 to assess how twenty-five years of family planning have affected women's lives. The Women's Studies Graduate Program also set up the Convention Watch Working Group in 1994 to strengthen the implementation of the Women's Convention in Indonesia through programs directed at strategic groups that have a multiplier effect, such as women's organizations, the media, and legal aid associations. WOMEN'S STUDIES GRADUATE PROGRAM, UNIVERSITY OF INDONESIA, *Are the Principles Contained in Article 11 of the Convention on the Elimination of All Forms of Discrimination Against Women Embodied in the Indonesian Laws and Regulations?*, INDONESIA CONVENTION WATCH WORKING GROUP RESEARCH STUDIES (1996).

and the principles of universality provide a philosophical and ethical basis for change. But they also evoke obstructive dichotomies in an area as intimate as human reproduction and as explosive as women's autonomy and sexuality. The Cairo and Beijing conferences and aftermath are illustrative of the ways in which the rights rhetoric can be manipulated by dominant elites in different countries and cultures to maintain existing hierarchies of gender, class and power. Activists and others engaged in women's health advocacy have to remain constantly alert to the ways in which their own language can be used to subvert their cause.

In arguing for action-oriented strategies to advance reproductive health goals, it is not the purpose of this article to understate the need for and importance of women's individual and collective struggles for the recognition and protection of their human rights, especially reproductive rights. Rather, it is to highlight the ways in which the rights discourse, by being intrinsically political, can result in the suppression of women and the continued denial of their health needs in so critical and contested a domain as human reproduction.

In an ideal world, responsive reproductive policy would seek to expand the exercise of human rights through rights-oriented socioeconomic development, equal rights for women, and the promotion of reproductive health and rights, with fertility reduction being an incidental outcome. Considering the realities of the present-day, advocacy strategies in reproductive rights will falter and stumble unless they focus their attention on one aspect of the over-arching rights framework. That aspect is the feasible, but by no means simple, objective of replacing population policies with reproductive health policies, enabling women, and men, to achieve their reproductive intentions healthfully and with human dignity.